Exhibit C

West Texas Neurology Clinic
318 N Alleghaney Suite 302
Odessa, TX 79761
(432)332-8858
FAX (432)332-8860

21512-081
Lonkey

Patient: Lonkey Jr, Millard, DOB: 07/22/1953, Age: 64 years, Male
Acct #: 16002, Encounter Date: 06/22/2018

New Patient Encounter
06/22/2018

Referral from Bureau of Prisons, Health Services

HEALTH SERVICES UNIT
FCI BIG SPRING

Chief Complaint(s): Leg pain

History of Present Illness:
This is a 64-year-old right-handed male referred for evaluation of left leg radicular symptoms. Symptoms started about 2 years ago after a bus ride from Oklahoma. He has low back pain. It is described as a burning sensation. Moderate in severity. Reportedly constant in duration. Pain radiates down the left leg also in a constant manner. He states there is some left leg weakness. Laying down makes the symptoms better. Prolonged standing makes symptoms worse. He has been put on gabapentin 900 mg twice a day and this has been helping. Nevertheless he continues to have some mild left leg weakness.

There is no associated urinary or fecal incontinence.

He had a CT scan of his lumbosacral spine done on May 11, 2018 at Scenic Mountain Medical Center. It showed a left posterolateral broad-based disc protrusions at L3-L4 and L4-L5 with associated neuroforaminal stenosis at L3-L4. There is borderline mild spinal stenosis at L2-L3 and L3-L4.

Medical History
Alcoholism.
COPD,emphysema.
Hypertension.

Surgical History
Back surgery.

Family History
Father - Alcoholism, Alzheimer's, High Blood Pressure.
Mother - Deceased, Alzheimer's, High Blood Pressure.

Allergies: No known drug allergies

Current Medications:
gabapentin 600 mg tablet 1 1/2 tablet by mouth twice a day X 30 Days, Disp. 90 Rfl #5
hydrochlorothiazide 25 mg tablet Take 1 tablet by mouth once a day
lisinopril 20 mg tablet Take 1 tablet by mouth once a day
Proventil HFA (albuterol sulfate) 90 mcg/actuation HFA aerosol inhaler Inhale 2 puff using inhaler every six hours
tamsulosin 0.4 mg capsule Take 1 capsule by mouth once a day X 1 Days, Disp. 1 NR

Review of Systems:
Constitutional Symptoms: Denies fever, chills, fatigue.
Eyes: Denies vision loss, blurring, diplopia.
Ears, nose, throat: Denies decreased hearing, difficulty swallowing, ear discharge.
Cardiovascular: **Complains of shortness of breath on exertion.** Denies chest pain, difficulty breathing at night.

West Texas Neurology Clinic
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Odessa, TX 79761
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Patient: Lonkey Jr, Millard, DOB: 07/22/1953, Age: 64 years, Male
Acct #: 16002, Encounter Date: 06/22/2018

Pulmonary: **Complains of shortness of breath.** Denies cough, non productive, dyspnea at rest, dyspnea on exertion.
Gastrointestinal: Denies nausea, vomiting, altered bowel habits.
Genitourinary: Denies Pain on urination, Urinating frequently, Urinary incontinence.
Musculoskeletal: **Complains of back pain.** Denies joint pain.
Neurological: **Complains of numbness of the face, numbness of extremities.**
Psychiatric: Denies depression, anxiety.
Endocrine: Denies heat intolerance, cold intolerance, recent weight change.

Vitals:
Height 71 inches (180.34 cm) **Weight** 222 pounds (100.7 kg) **BMI** 30.95 **Pulse** 96 bpm **Blood Pressure** 145 / 96

Exam:
Constitutional: ***general appearance***: well hydrated, well nourished.
Musculoskeletal: ***gait and station***: smooth gait and upright posture.
Neurologic: ***orientation***: orientation – oriented to time, place and person.
memory: recent and remote memory intact.
attention span: able to stay focus during the exam.
language: Speech is normal; no dysarthria; no aphasia.
fund of knowledge: mood and affect appropriate for age.
2nd cranial nerve: Pupils – equal round and reactive to light; Visual field are normal to confrontational testing.
3rd, 4th, 6th cranial nerves: Normal extraocular movements and alignment of gaze, No ptosis noted.
7th cranial nerve: No facial asymmetry.
8th cranial nerve: hearing is normal.
sensation: Decrease pin – dermatomal distribution – Left L5.
deep tendon reflexes: Biceps, Brachioradialis, knee, and ankle reflexes are 2+ and symmetric.
Cardiovascular: ***peripheral circulation***: no cyanosis, clubbing, edema, or varicosities.
Additional Info There is mild weakness and left tibialis anterior 4+/5. As well as the left medial gastrocnemius 4+ out of 5.

Problems
Spondylosis with radiculopathy, lumbar region (ICD-10: M47.26), Status: Active, onset: 06/22/2018 (added)

Medications
Medication Reconciliation Performed

Plan Note
1. Agree with gabapentin 900 mg twice a day. May increase to 900 mg 3 times a day if symptoms worsen.
2. Recommend another course of physical therapy.
3. Neurosurgical consultation is also recommended given patient does have mild left distal leg weakness.

Disposition
Return to clinic if symptoms persist

Note Contributing Authors:
Joseph Albert Abijay, MD; Doraima Jimenez

West Texas Neurology Clinic
318 N Alleghaney Suite 302
Odessa, TX 79761
(432)332-8856
FAX (432)332-8860

Patient: Lonkey Jr, Millard, DOB: 07/22/1953, Age: 64 years, Male
Acct #: 16002, Encounter Date: 06/22/2018

Note electronically signed by: Joseph Albert Abijay, MD on 06/22/2018 at 08:53 PM

CC:
Bureau of Prisons, Health Services, 1900 Simler Avenue, Big Spring, TX, 79720

FCI BIG SPRING
1900 SIMLER AVENUE
BIG SPRING, TEXAS 79720

Conkey #2512-081

Scenic Mountain Medical Center
1601 West 11th Place
Big Spring, TX 79720
432 263 1211

IMAGING REPORT

NAME: LONKEY, MILLARD J

MRN:	274159	ROOM:	DOB: 07/22/1953
ACCOUNT#:	3725942	BED:	AGE: 64 Y
PATIENT TYPE:	RAD	ORDER DATE/TIME: 05/11/2018 09:00	SEX: M

ORDER #:	EXAM DESCRIPTION:	ADM DIAGNOSIS:
100	CTLSPWO	

ACCESSION #: 37259420000100

DICTATED BY: CASTILLO, MARIO MD, PH.D.
ORDERING PHYSICIAN: BALLOM, TE
ATTENDING PHYSICIAN: BALLOM, TE
PRIMARY CARE PHYSICIAN: UNKNOWN, PRIMARY

FINAL REPORT

ADDENDUM

IMPRESSION

2. Left posterolateral broad-based disc protrusions at L2-L3 and L3-L4 (NOT L4-L5) with associated neuroforaminal stenosis at L3-L4 as described.

END OF ADDENDUM

NONENHANCED CT LUMBAR SPINE

REASON FOR EXAM: Lumbago with radiculopathy.

Multiple contiguous axial images were obtained at 1 mm collimation, as per protocol. Sagittal and coronal images were reconstructed from the acquired data. This examination was performed using one or more of the following dose reduction techniques: Automated exposure control, adjustment of the mA and/or kV according to patient's size and/or use of iterative reconstruction technique.

Lack of intrathecal contrast limits assessment of the discs, conus medullaris, and nerve roots.

No previous CT examinations of the lumbar spine are available for comparison.

Correlation is made with a CR series of the lumbar spine dated 04/19/2016 and with an MRI examination of the lumbar spine dated 08/25/2017.

IMAGING REPORT

NAME: LONKEY, MILLARD J

MRN: 274159 DOB: 07/22/1953
ACCOUNT#: 3725942 ORDER DATE/TIME: 05/11/2018 09:00

ORDER #: 100 EXAM DESCRIPTION: CTLSPWO ADM DIAGNOSIS:

For the purposes of labeling, a transitional vertebra at the lumbosacral junction of the spine is designated as L5.

Loss of lordosis and mild dextroconvex rotary scoliosis are noted. The vertebrae align anatomically without evidence of acute fracture or subluxation. L4 and L5 exhibit asymmetric bony fusion on the left with a prominent anterolateral bridging osteophyte. Other levels exhibit conservation of disc height versus minimal to mild narrowing and mild juxtaendplate osteophytic ridging.

At all examined motion segments, there is a congenitally-small spinal canal on the basis of short pedicles. Bilaterally, the exiting nerve roots are grossly unremarkable and the facet joints exhibit arthrosis.

The annulus fibrosus shows mild diffuse concentric bulging at L2-L3 through L4-L5 with left posterolateral eccentricity versus broad-based disc protrusions at L2-L3 and L3-L4, moderately narrowing the ipsilateral neuroforamen at L3-L4.

The ligamentum flavum exhibits hypertrophy at L2-L3 and L3-L4 with an associated reduction in the cross-sectional area of the spinal canal, greater at L3-L4.

The neuroforamina show narrowing bilaterally at T10-T11 (mildly), on the right at T11-T12 (mildly) and T12-L1 (mildly), bilaterally at L3-L4 (mildly on the right and moderately on the left) and L4-L5 (mildly on the right and moderately on the left).

Mild symmetrical narrowing of the sacroiliac joint spaces arises in association with mild irregularity of articular surfaces.

Incidental findings include:

Calcified atheromatous plaques arise predominantly in a nonaneurysmal abdominal aorta, about the ostia of the celiac, superior mesenteric and bilateral renal arteries and in the iliac arteries bilaterally.

Extrarenal pelves reflect a normal developmental variant.

IMPRESSION

1. No CT evidence of acute fracture. If clinical symptoms persist, correlation with magnetic resonance imaging is advised.
2. Left posterolateral broad-based disc protrusions at L3-L4 and

IMAGING REPORT

NAME: LONKEY, MILLARD J

MRN: 274159 DOB: 07/22/1953
ACCOUNT#: 3725942 ORDER DATE/TIME: 05/11/2018 09:00

ORDER #: 100 EXAM DESCRIPTION: CTLSPWO ADM DIAGNOSIS:

L4-L5 with associated neuroforaminal stenosis at L3-L4 as described.
3. Borderline to mild spinal canal stenosis at L2-L3 and L3-L4.
4. Spondyloarthropathy with associated findings as noted above.

D Date / Time: 05/11/2018 10:57 AM CT
T Date / Time: 05/11/2018 11:27 AM CT
R Date / Time:
S Job #: SMMC90431718
D Job #: 6412551
MT: 570862
D: MC

Mario J Castillo, MD, Ph.D.

This document is electronically signed by: Mario J Castillo MD, Ph.D. on 05/11/2018 at 2:47:08 PM (CST) Verification: 904323142018051114470S

Print CC:

Fax CC:
TE CORA BALLOM, DO

D Date / Time: 05/11/2018 11:51 AM CT
T Date / Time: 05/11/2018 12:54 PM CT
R Date / Time: 05/11/2018 1:59 PM CT
S Job #: SMMC90432314
D Job #: 6412561
MT: 570862 / 30800
D: MC

#21572-081

Name: Millard Lonkey
DOB: 7/22/1953
Age: 64
Date: 11/29/2017

Health Services Unit
FCI Big Spring

CHIEF COMPLAINT: Lower back pain

HISTORY of PRESENT ILLNESS: This is a 64 year old male with lower back pain X 2-3 years. He previously had back pain many years ago, but he had back surgery in approximately 1990 and that relieved the pain. He reports the pain stared after a long bus ride. He has pain in his lower back and it radiates down his left leg. He has numbness, tingling, and weakness in his left leg as well. He takes gabapentin with some relief of symptoms. He tried physical therapy with no improvement in pain.

ALLERGIES: NKDA

MEDICATIONS: Gabapentin, tamsulosin, lisinopril, HCTZ

SOCIAL HISTORY: Pt. is an inmate in Big Spring, Texas. Pt. denies drinking alcohol or history of drug abuse. Pt. previously smoked cigarettes, but he quit now.

FAMILY HISTORY: Positive for DM, cancer, and HTN.

PAST MEDICAL HISTORY: HTN

SURGICAL HISTORY: L4-L5 laminectomy in 1990, appendectomy, tonsillectomy

REVIEW OF SYSTEMS:
GENERAL: Negative
EYES: Blurred vision, double vision, glasses
ENT: Negative
CV: Negative
RESP: Cough, SOB, wheezing
GI: Negative
MUSCULO: Low back pain, left leg pain
NEURO: Negative
PSYCH: Depression
SKIN: Negative
GU: Negative
ENDOCRINE: Negative

PHYSICAL EXAM: Height: 5'11 Weight:225 pounds
HEAD: Head is normocephalic and atraumatic
CV: Heart rate rhythm is regular. No murmurs or gallops

PULM: Lungs are clear to auscultation
ABD: Soft and non-tender
EXT: No clubbing, cyanosis, or edema noted

NEUROLOGICAL: Normal neurological examination except noted:

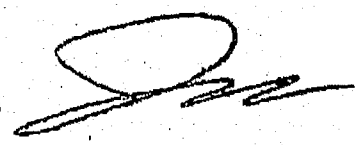
Motor	Left	Right
Deltoids:	5/5	5/5
Biceps:	5/5	5/5
Triceps:	5/5	5/5
Hand-grips:	5/5	5/5
Wrist Extensions:	5/5	5/5
Wrist Flexions:	5/5	5/5
Iliopsoas:	5/5	5/5
Quadriceps:	5/5	5/5
Anterior Tibialis:	5/5	5/5
EHL:	5/5	5/5
Gastrocnemius:	5/5	5/5

RADIOGRAPHIC: MRI of the L-spine without contrast was performed at Scenic Mountain Medical Center on 8/25/2017 and demonstrates: L4-L5 central stenosis, left paracentral disc protrusion with left foraminal narrowing

ASSESSMENT/PLAN: This is a 64 year-old male with lumbar pain and radiculopathy. He has failed conservative therapy. We believe that he will likely need L4-L5 laminectomy with probable fusion. We would like to send him for a CT scan of the L-spine first and have him followup after imaging. Discussed plan with patient, he agrees with plan of care.

TOBACCO ASSESSMENT: Smoking Status: Previous smoker.

Counseling on tabacco cessation: Yes.



CLINIC NOTE

Name: LONKEY, MILLARD J

MRN:	73215	DOB:	07/22/1953
Account #:	72253	DOS:	10/24/2017

FAMILY HISTORY: Mother died of Alzheimer's issues and heart attack. Dad is living. He has emphysema and otherwise unknown. He had not kept up with him.

SOCIAL HISTORY: Positive for tobacco and alcohol. He quit in July 2014. He had about a 45 plus-pack-year history. He denies drugs.

MRI of his lumbar area showed a stable left posterior lateral disk protrusion, neural foraminal stenosis at L3 and L4, stable spondyloarthropathy. Again, images were reviewed.

VITAL SIGNS: We have him at 5 feet 11 inches and 224 pounds. Temp 97.6, pulse 87, respirations 17, blood pressure 153/92, saturating 98% on room air.

The patient does walk the yard. He denies shortness of breath unless he walks fast, and sometimes when he bends over to make his bed, he also has some shortness of breath. He is morbidly obese. He said that the pain has been going on about 3 years in the abdomen, it stays about the same. He says, he feels it more at night. There is nothing that really makes it significant, better. He said it is in the mid epigastric region below the xiphoid. It might have a small amount of diastasis in that area as well.

PHYSICAL EXAMINATION:
General: A well-developed and well-nourished male, in no acute distress. Normocephalic and atraumatic. Alert and oriented x3. Appropriate affect. Slightly blunted.
HEENT: Pupils are equal, round, and reactive to light. Equal ocular motions intact. No icterus. Conjunctivae pink and moist. Lids normal. Turbinates pink. Oropharynx, no significant findings.
Neck: Supple. No lymphadenopathy. Trachea midline. No JVD. 2+ carotid pulses. No bruits.
Lungs: Clear to auscultation bilaterally. No increased work of breathing. Symmetric rise and fall of the chest.
Heart: S1 and S2. No specific murmurs, rubs, or gallops.
Abdomen: Morbidly obese, minimal tenderness to midepigastric region, very firm abdomen, significant subcutaneous fat noted. Hypoactive bowel sounds. With him standing, there is no significant protrusion in the groins. With a finger placed up the inguinal canal, there is slight weakness in the inguinal floor with increased intraabdominal pressure of a cough, in the right is slightly larger than the left, but no other significant masses or lesions.
Extremities: Strength is appropriate, upper and lower. 2+ pulses at the wrists and the ankles.
Skin: Warm, dry, and intact. No cyanosis, clubbing, or edema.
Neurological: No cranial nerve deficits appreciated. No other significant weaknesses noted.

ASSESSMENT: A 64-year-old gentleman with some epigastric pain and discomfort.

PLAN: Due to the increased stool seen on the CAT scan done on October 20, 2017, with start:
1. With a stool softener, Colace 100 mg twice a day. Do that for 2 to 3 weeks and see if there is a decrease in the issues of abdominal discomfort. He can reduce down to 1 Colace a day. I would increase his fluid to make sure he has plenty of fiber in his diet as well.
2. Start a low-dose omeprazole 20 mg once a day just to make sure that this is not a gastrointestinal issue related to the stomach. I did not see anything specific on the CAT scan to infer that, but it may help. So stool softener twice a day for 2 to 3 weeks as a trial. Also add 20 mg of omeprazole once a day. Re-evaluate and assess in 2 to 3 weeks. The hernias in the inguinal region appeared to be asymptomatic, they are not limiting the patient's lifestyle, and it is not this area of pain or discomfort, so I would not

Lonkey
21512-081

HEALTH SERVICES UNIT
FCI BIG SPRING

Scenic Mountain Medical Center
1601 West 11th Place
Big Spring, TX 79720
432 263 1211

IMAGING REPORT

NAME: LONKEYJR, MILLARD J

MRN:	274159	ROOM:	DOB: 07/22/1953
ACCOUNT#:	3697602	BED:	AGE: 64 Y
PATIENT TYPE:	RAD	ORDER DATE/TIME:	08/25/2017 10:18 SEX: M

ORDER #:	EXAM DESCRIPTION:	ADM DIAGNOSIS:
100	MRILSPWW	

ACCESSION #: 36976020000100

DICTATED BY: CASTILLO, MARIO MD, PH.D.
ORDERING PHYSICIAN: BALLOM, TE
ATTENDING PHYSICIAN: BALLOM, TE
PRIMARY CARE PHYSICIAN: UNKNOWN, PRIMARY

FINAL REPORT

MRI LUMBAR SPINE WITH AND WITHOUT INTRAVENOUS ENHANCEMENT

REASON FOR EXAM: Lumbago with radiculopathy.

Multiple T1- and T2-weighted axial and sagittal images were obtained. STIR sagittal images were also acquired. Fat-saturated T1-weighted axial and sagittal images were obtained after intravenous administration of gadolinium contrast, as per protocol.

Compared to an MRI examination of the lumbar spine dated 04/07/2016.

Correlation is made with a CR series of the lumbar spine dated 04/19/2016.

The conus medullaris terminates at T12, showing no focal enlargement or abnormal signal. The nerve rootlets of the cauda equina layer dependently and fan out normally without evidence of clumping or adhesions.

There is a normal bone marrow signal for the patient's age without evidence of marrow edema to suggest bone bruise/contusion, occult or acute fracture. A stable, rounded, circumscribed, subcentimeter focus of T1 and T2 hyperintensity in the body of L5, most likely represents an incidental hemangioma. Vertebral body height is preserved.

For the purposes of labeling, a transitional vertebra at the lumbosacral junction of the spine is designated as L5.

Loss of lordosis and mild rotary scoliosis are again noted. Stable marked loss of disc height at L4-L5 arises in association with

IMAGING REPORT

NAME: LONKEYJR, MILLARD J

MRN: 274159 DOB: 07/22/1953
ACCOUNT#: 3697602 ORDER DATE/TIME: 08/25/2017 10:18

ORDER #:	EXAM DESCRIPTION:	ADM DIAGNOSIS:
100	MRILSPWW	

irregularity of opposing endplates and a bulky bridging anterolateral osteophyte on the left. Other levels exhibit conservation of disc height versus minimal to mild narrowing and mild juxtaendplate osteophytic ridging. All discs show loss of T2 signal, greatest at L4-L5, compatible with desiccation.

At all examined motion segments, the bilateral exiting nerve roots are grossly unremarkable and the facet joints exhibit arthrosis.

These are salient findings at the following levels:

At T-L1 and L1-L2, there is no evidence of bulging of the annulus fibrosus, focal disc protrusion or spinal canal stenosis. Bilaterally, the neuroforamina remain widely patent.

At L2-L3, the annulus fibrosus shows stable mild diffuse concentric bulging with left posterolateral eccentricity but without evidence of discrete focal disc protrusion or spinal canal stenosis. Bilaterally, the neuroforamina remain widely patent.

At L3-L4, the cross-sectional area of the spinal canal demonstrates a stable mild multifactorial reduction in size: The annulus fibrosus shows diffuse concentric bulging with left posterolateral eccentricity and broad-based disc protrusion, moderately narrowing the ipsilateral neuroforamen as on the prior study. The right neuroforamen shows stable mild narrowing. There is mild hypertrophy of the ligamentum flavum.

At L4-L5, the annulus fibrosus shows mild diffuse concentric bulging without evidence of focal disc protrusion or spinal canal stenosis. Bilaterally, the neuroforamina show stable mild narrowing.

At L5-S1, there is no evidence of bulging of the annulus fibrosus, focal disc protrusion or spinal canal stenosis. Bilaterally, the neuroforamina remain widely patent.

Incidental findings include:

The imaged urinary bladder exhibits mild trabeculation.

IMPRESSION

1. Stable left posterolateral disc protrusion, neuroforaminal stenosis and borderline spinal canal stenosis at L3-L4 as described.

- IMAGING REPORT

NAME: LONKEYJR, MILLARD J

MRN: 274159 DOB: 07/22/1953
ACCOUNT#: 3697602 ORDER DATE/TIME: 08/25/2017 10:18

ORDER #:	EXAM DESCRIPTION:	ADM DIAGNOSIS:
100	MRILSPWW	

2. Stable spondyloarthropathy with associated findings as noted above.

-

Mario J Castillo, MD, Ph.D.

- This document is electronically signed by: Mario J Castillo MD, Ph.D. on 08/25/2017 at 2:01:26 PM (CST) Verification: 882953732017082514012 6

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Print CC:
-
Fax CC:
TE CORA BALLOM, DO

D Date / Time: 08/25/2017 12:57 PM CT
T Date / Time: 08/25/2017 01:21 PM CT
R Date / Time:
S Job #: SMMC88295373
D Job #: 51083
MT: 570862
D: MC

SHANNON CLINIC | 120 E. Beauregard San Angelo, TX 76903 | Phone: (325) 659-1511

Signed Final Copy

Patient: LONKEY, MILLARD Patient ID: 443579 Date: 8/2/2016

Neurosurgery New Patient Office Visit 8/2/2016

21512-081

Patient: **LONKEY, MILLARD** *443579*

DOB: 7/22/1953 / M

Referring Provider:

Primary Care Provider:

Health Services Unit FCI BIG SPRING

Chief Complaint: CHRONIC BACK PAIn

History of Present Illness:

MILLARD is a 63 yr old, right handed patient who comes in today with complaints of CHRONIC BACK PAIN. The pain radiates to left leg. He is having pain into the shin. The patient was on a long bus trip and began having pain down his legs. He was given some ibuprofen. He states that he ended up in a wheelchair because he could not walk due to the pain. The patient was on gabapentin which he states was helping him. He was taking 900 mg twice a day. The gabapentin was discontinued and he was placed on Cymbalta which made him ill. The patient complains of a burning sensation. The patient rates their pain at a 5 on a 1-10 pain scale. The patient complained of neck stiffness. The patient complained of tightness in the lower back. The patient is able to hot water. The patient has been to 0 physical therapy sessions in the last year. The patient has had 1 epidural steroid injections in the last year. The patient has had 0 facet blocks in the last year. The patient has had 0 nerve blocks in the last year. The patient has had 0 SI joint injections in the last year. The patient has had 0 genicular injections in the last year. The patient has seen a chiropractor 0 times. The patient has not had any loss in bowel or bladder control. The patient utilizes no assistive devices.

The patient was assesed using the Oswestry Disability Index questionaire. PAIN INTENSITY: pain medication provides complete relief from pain. PERSONAL CARE: painful. Must be slow and careful. LIFTING: manages to lift ligt to medium weight from a table. WALKING: no more than 0.5 a mile. SITTING: no more than 1 hour. STANDING: no more than 30 minutes. SLEEP: pain meds allow 6 hours. SEX LIFE: normal. SOCIAL LIFE: unrestricted. TRAVEL: pain is bad but manages 2 hour journeys. The patient is at 36% disability on the Oswestry Disability Index.

Please refer to completed SF-12 form at this office visit.

Past Medical History:

1. History of hypertension

Past Surgical History:

1. Tonsillectomy
2. Appendectomy
3. Lumbar Laminectomy right side

Family Medical History:

1. Father: diabetic copd
2. Mother: hypertension dementia
3. 1 Sibling(s):
4. Family history of dementia

6. Family history of hypertension

Social History:

1. Former smoker
2. Chewing tobacco
3. Not using drugs
4. 3 children
5. Not exercising regularly
6. Not currently employed
7. Previous military service
8. No travel or residence in a foreign country
9. Currently wearing eyeglasses
10. Not wearing contact lenses
11. Not wearing dentures
12. Orthodontic braces were not being worn

Medications:

Flomax (tamsulosin) 0.4 mg, 1, once a day
Hydrochlorothiazide 25 mg, 1, once a day
Lisinopril 10 mg, 1, once a day

Allergies:

NKDA
Other, (with verbal denial of Iodine, IVP or Contrast dyes)

Vitals:

Temp: 96.3 Height: 5 ft 11 in Weight: 209 lb 0 oz Blood Pressure: 130 /78 Pulse: 71

Review of Systems:

General: No weight change. No fever. No chills. Positive for dizziness. Positive for weakness. Positive for fatigue.

Eye: No discharge. No vision loss. No change in vision. No redness. No pain. No blurred vision.

ENT: No sore throat. No rhinorrhea. No throat swelling. No nosebleeds. No hoarseness. No hearing loss.

Cardiovascular: No chest pain. Positive for lower extremity edema. legs and feet . No tachycardia. No palpitations.

Respiratory: Positive for cough. No hemoptysis. Positive for shortness of breath. No dyspnea on exertion.

Gastrointestinal: Positive for nausea. No vomiting. No diarrhea. No constipation. No melena. No dysphagia.

Genitourinary: No dysuria. No hematuria. No frequency. No dyspareunia. No flank pain.

Musculoskeletal: Positive for myalgias. Positive for arthralgias. Positive for neck pain. Positive for back pain.

Skin: No rash. No contusions. No abrasions. No lacerations.

Neurological: Denies headache. Positive for numbness. left leg . No weakness. Positive for paresthesias. left leg .

Psychological: No change in mental status. No confusion. No agitation. Not suicidal. Denies depression. Not hostile.

Metabolic: Denies polyuria. Denies polydipsia. No hair loss. Positive for heat intolerance.

Hematologic: No bleeding. Does not easily bruise.

Physical Exam:

General: The patient is well developed. Appears approximate stated age. Is pleasant and cooperative throughout examination. Appears in no acute distress.

Respiratory: Respirations are even and unlabored. Breath sounds are clear throughout all lobes.

Cardiovascular: Heart has a regular rate and rhythm. No murmur. No audible pericardial friction rub. No gallop. No peripheral edema.

Gastrointestinal: Abdomen is soft. Abdomen nontender. Bowel sounds are present throughout all quadrants.

Genitourinary: Deferred.

Skin: No rash seen. No bruising. No skin discoloration.

Musculoskeletal: Gait is normal. Station is normal. Right Iliopsoas 5/5. Left Iliopsoas 5/5. Right Quadricep 5/5. Left Quadricep 5/5. Right Hamstring 5/5. Left Hamstring 5/5. Right Tibialis anterior 5/5. Left Tibialis anterior 4/5. Right Extensor hallucis longus 5/5. Left Extensor hallucis longus 5/5. Right Gastrocnemius 5/5. Left Gastrocnemius 5/5.

Neurologic: The patient is alert and oriented to person, place and time. L4 and S1 reflexes are 2+.

Imaging:

CD/ROM FROM SCENIC MOUNTAIN MEDICAL CENTER:
MRI OF THE LUMBAR SPINE (4/07/16)
IMPRESSION:
1. Left posterolateral disc protrusion, neural foraminal stenosis and borderline spinal canal stenosis at the L3-4 as described.
2. Spondylarthropathy with associated findings as noted above.

Impression:

1. Low back pain with radiculopathy.

2. Left posterolateral disc protrusion, neural foraminal stenosis and borderline spinal canal stenosis at the L3-4 as described.

Plan:

The patient is here today with back pain. I have reviewed the MRI images of the lumbar spine. We will place the patient on gabapentin 600 mg twice a day. We will order physical therapy 2 times a week for 3 weeks. We will prescribe Tramadol 50 mg to take 1 p.o. t.i.d. p.r.n. pain. The patient will be seen in follow up in 4 weeks. The patient was given written material with exercises to do, should physical therapy not be approved.

Documentation assistance provided by Sandra Michulka who functioned as a medical scribe and was present during the visit. History, physical examination, assessment and plan were performed personally by the doctor.

KRISTIN RAMIREZ, CNS

Electronically Signed By: Kristin Ramirez, CNS 8/2/2016 1:15:00 PM

Ophthalmology Offsite Appt

Reason for Request:

66 years male with Hx. of vertical diplopia for one year needs to follow up with ophthalmologist as per recommendations. Please, bring MRI of brain with and without contrast (ordered previously). Please, bring LAB: T3, Free T4, TSH FBS for appointment.

Provisional Diagnosis:

vertical diplopia

Disposition:

To be Evaluated by Provider

Patient Education Topics:

Date Initiated	Format	Handout/Topic	Provider	Outcome
10/23/2019	Counseling	Access to Care	Sosa, Halina	Verbalizes Understanding
10/23/2019	Counseling	Plan of Care	Sosa, Halina	Verbalizes Understanding

Copay Required: No **Cosign Required:** Yes
Telephone/Verbal Order: Yes **By:** Ballom, Te Cora DO RMD
Telephone or Verbal order read back and verified.

Completed by Sosa, Halina RN on 10/23/2019 13:14
Requested to be cosigned by Ballom, Te Cora DO RMD.
Cosign documentation will be displayed on the following page.
Requested to be reviewed by Alvarez, Javier MLP.
Review documentation will be displayed on the following page.

Bureau of Prisons
Health Services
Clinical Encounter

Inmate Name: LONKEY, MILLARD J JR
Date of Birth: 07/22/1953
Encounter Date: 08/27/2019 10:16
Sex: M Race: WHITE
Provider: Sosa, Halina RN
Reg #: 21512-081
Facility: BIG
Unit: S01

Nursing - Sick Call Note encounter performed at Health Services.

SUBJECTIVE:

COMPLAINT 1 **Provider:** Sosa, Halina RN

Chief Complaint: Eyes/Vision Problems
Subjective: Inmate complaining of diplopia in left eye.
Pain: No

OBJECTIVE:

Temperature:

Date	Time	Fahrenheit	Celsius	Location	Provider
08/27/2019	10:19 BIG	98.4	36.9		Sosa, Halina RN

Pulse:

Date	Time	Rate Per Minute	Location	Rhythm	Provider
08/27/2019	10:19 BIG	79			Sosa, Halina RN

Respirations:

Date	Time	Rate Per Minute	Provider
08/27/2019	10:19 BIG	16	Sosa, Halina RN

Blood Pressure:

Date	Time	Value	Location	Position	Cuff Size	Provider
08/27/2019	10:19 BIG	160/93				Sosa, Halina RN

SaO2:

Date	Time	Value(%)	Air	Provider
08/27/2019	10:19 BIG	95	Room Air	Sosa, Halina RN

Exam:

General

Appearance

Yes: Appears Well, Alert and Oriented x 3
No: Appears Distressed

Skin

General

Yes: Within Normal Limits, Dry, Skin Intact

Eyes

General

Yes: PERRLA

Pulmonary

Observation/Inspection

Yes: Within Normal Limits
No: Respiratory Distress

Cardiovascular

Bureau of Prisons
Health Services
Vision Screens

Reg #: Inmate Name:

Vision Screen on

Blindness:

Distance Vision: OD: OS: OU:

Near Vision: OD: OS: OU:

With Corrective

Distance Vision: OD: 20 OS: 25 OU:

Near Vision: OD: OS: OU:

Present Glasses - Distance

	Sphere	Cylinder	Axis	Add
R:				
L:				

Refraction - Distance

	Sphere	Cylinder	Axis	Add	
R	+4.75	-1.00	89		20
L	+5.50	-1.50	166		25

Color Test:

Tonometry: R: L:

Comments:

Orig Entered:

A: Dx = III & IV N palsey by Dr H Shah

P: Rx achieved some adaptation will be required

LONKEY, MILLARD
21512-081 19
DOB: 07-22-1953
66

J. Marshall, OD
Contract Optometrist

Patient: LONKE[illegible] HARSHAD G. SHAH
Account 63588 Birthdate 07/22/1953 M Age 66
Primary Doctor
Referring Doctor:
Exam 10/23/19

4214 Andrews Highway
Suite 105
Midland, TX 79703

Phone (432) 686-2020
Fax 4325700080

#21512-081

Health Services Unit
FCI Big Spring

Appointments

10/23/19 NP 8:30a HGS

Problem List

10/23/19	H18.41	Arcus senilis, bilateral	HGS
10/23/19	H02.40	Unspecified Ptosis Of Left Eyelid	HGS
10/23/19	H49.23	Sixth [abducent] nerve palsy, bilateral	HGS
10/23/19	H49.03	Third [oculomotor] nerve palsy, bilateral	HGS
10/23/19	H53.2	Diplopia	HGS

Chief Complaint

Millard Lonkey Jr, 66 year old male, Is a new patient who presents for dilated examination. double vision left eye, since June 2018, and gradually came on, It first started last year off & on, and now has occasional headaches when not wearing glasses. States image is lower to right, and left eye is turning up and out.

HPI

Location	Left Eye
Quality	double vision.
Severity	worse
Timing	The symptoms beganJune 2019

Ocular History

2019/10/23	Illness	No Known Ocular Illness
2019/10/23	Trauma	No Known Ocular Trauma
2019/10/23	Procedure	No Known Ocular Procedures

Medical History

2019/10/23	Trauma	No known trauma
2019/06	Illness	Cardiovascular
2016		Emphysema/COPD
2014		HTN
	Procedure	Appendectomy
		Back Sx
		Tonsillectomy
	Family	
	Social	Denies drinking

Smoking Status

Smoke — Never smoker. / 266919005

Systemic Medications

- lisinopril
- amlodipine
- tamsulosin
- gabapentin
- hctz
- mometasone
- aspirin 325 mg tablet,delayed release (DR/EC) (aspirin)

Review of Systems

Constitutional	Unremarkable
Eyes	See ocular exam.
ENMT	Unremarkable
Cardiovascular	pleurisy
Respiratory	Unremarkable
Gastrointestinal	Unremarkable
Genitourinary	Unremarkable
Integumentary.	Unremarkable
Musculoskeletal	Unremarkable
Neurological	Unremarkable
Hematologic	Unremarkable
Immunologic	Unremarkable
Endocrine	Unremarkable
Psychiatric	Unremarkable

Mood/Orientation

Mood/Oriented — Mood normal, Alert and Oriented x3 (426224004)

Visual Acuity

10/23/19 DS - VA

Eye	scDva	scNva	ccDva	ccNva	phDva	Glare	PAM
OD			20/30				
OS			20/25				

Refractions

Auto Refraction 10/23/19 CO

Eye Rx	Add	Prism Base	Prism Base	Dva	Nva
OD +1.00-1.00x090					
OS -0.50-0.50x177					
OU					

Manifest 10/23/19 DS

Eye Rx	Add	Prism Base	Prism Base	Dva	Nva
OD +1.00-1.00x090	+2.25			20/20	
OS -0.50-0.75x180	+2.25			20/25	
OU					

Final Rx 10/23/19 DS

Eye Rx	Add	Prism Base	Prism Base	Dva	Nva
OD +1.00-1.00x090	+2.25			20/20	
OS -0.50-0.75x180	+2.25			20/25	
OU					

Keratometry

10/23/19 CO	OD	OS
	43.00@093	42.75@087
	44.00@003	43.75@177
	1.00@003	1.00@177

External Exam

	OD	OS
Pupils	PERRL (-) APD	PERRL (-) APD
Motility	can not move right eye up	Extraocular Movements Intact, Normal Gaze Alignment.
Muscle Balance	Ortho by ACT	Ortho by ACT
Confrontation Fields	Normal Confrontational Field	Normal Confrontational Field
External Lids	normal lid position without obvious lesions	ptosis
Orbit / Adnexa	no proptosis or visible mass	no proptosis or visible mass

IOP

		OD	OS	Method	Staff	Comments
10/23/19	12:28P	7	7	Goldmann	DS	

Patient LONKEY JR, Millard J. Harshad G. Shah Md Pa Eye Institute Dr. HARSHAD G. SHAH
Account 19559 Birthdate 07/22/1953 M Age 66 4214 Andrews Highway Phone (432) 686-2020
Primary Doctor Suite 105 Fax 4325760293
Referring Doctor Midland, TX 79703 Page 2
Exam 10/23/19

C/D Ratio

Date	OD Vertical	OD Horizontal	OS Vertical	OS Horizontal	Staff	Comments
10/23/19	0.2	0.2	0.3	0.3	DS	

Drops Administered

Paremyd 8:30am
1.0%/0.25%

Slit Lamp Exam

	OD	OS
Lids / Lashes	retraction	Lid Margins Clear, Lashes Without Collarettes or Scurf
Tear film	normal tearfilm	normal tearfilm
Conjunctiva	Normal Bulbar and Palpebral.	Normal Bulbar and Palpebral.
Cornea	Arcus Senilis	Arcus Senilis
Anterior Chamber	Deep and quiet. No cell or flare.	Deep and quiet. No cell or flare.
Iris	no MG pupil	no MG pupil
Lens	1+ Nuclear Sclerosis.	1+ Nuclear Sclerosis.
Angles	angles appear open	angles appear open

Fundus

	OD	OS
Dilation	Dilated retinal examination was performed. Good dilation.	Dilated retinal examination was performed. Good dilation.
View	Good View	Good View
Optic Discs	Normal appearing optic nerve with healthy pink rim and normal appearing nerve fiber layer.	Normal appearing optic nerve with healthy pink rim and normal appearing nerve fiber layer.
Cup to Disc	C/D: 0.20.	C/D: 0.30.
Macula	Normal Color and Contour for Age	Normal Color and Contour for Age
Vessels	vessels are of normal caliber without arterio-venous nicking or significant tortuosity	vessels are of normal caliber without arterio-venous nicking or significant tortuosity
Periphery	Attached 360 Degrees, No Holes or Tears.	Attached 360 Degrees, No Holes or Tears.
Vitreous	Vitreous Normal and Clear for Age, No PVD.	Vitreous Normal and Clear for Age, No PVD.

Plan

10/23/19 HGS

- **1. Diplopia**

2. Third Nerve Palsy, Incomplete, OU – the patient has signs and symptoms consistent with bilateral incomplete third nerve palsies. The condition and possible etiologies were discussed with the patient.

3. Sixth Nerve Palsy OU – the patient has signs and symptoms consistent with bilateral sixth nerve palsies. The condition and possible etiologies were discussed with the patient.

4. Ptosis OS
T3 free T4 TSH, MRI with and without contrast.

5. Return for an appointment in 2 months with Dr. HARSHAD SHAH at The Eye Institute Midland.

Superbill

	99204	E/M New Patient Comprehensive Exam		HGS
H53.2		Diplopia		HGS
H49.03		Paralytic Strabismus, Third Or Oculomotor Nerve Palsy, Partial		HGS
H49.23		Paralytic Strabismus, Sixth Or Abducens Nerve Palsy		HGS
H02.402		Unspecified Ptosis Of Eyelid	OS	HGS
H18.413		Senile Corneal Changes		HGS
	92015	Refraction		HGS

Signature

HARSHAD G. SHAH, MD
10-28-2019 13:21:41

Bureau of Prisons
Health Services
Vision Screens

Reg #: Inmate Name:

Vision Screen on

Blindness:

Distance Vision: OD: /30 OS: /30 OU:

Near Vision: OD: OS: OU:

With Corrective

Distance Vision: OD: OS: OU:

Near Vision: OD: OS: OU:

Present Glasses - Distance	Sphere	Cylinder	Axis	Add
R:				
L:				

Refraction - Distance	Sphere	Cylinder	Axis	Add
R:				
L:				

Color Test:

Tonometry: R: 11 L: 11

Comments:
Orig Entered:

C/D .25
.3

Reports BP not well controlled

Dipl 3 mon shew onset
CT: XT OS c̄ hypertropia
Pupils: equal, round
[illegible] direct - APD
conf Fields: Full
macula: cl
Retina: Flat 360° OU

A: XT OS c̄ hyper deviation + resulting visual confusion.

P: F/U complete work up c̄ imaging r/o [illegible] problem

LONKEY, MILLARD
21512-081
DOB: 07*22-1953

[signature], OD

J. Marshall, OD
Contract Optometrist

21512-081

Health Services Unit
FCI Big Spring

Hendrick Health System
ABILENE, TEXAS
Department of Radiology & Nuclear Medicine

LONKEY JR, MILLARD
Account Number: 50716158 MRN: 1482813
DOB: 07/22/1953 Completed on: 10/31/2019 09:06
MRORWW MRI ORBITS, FACE, AND/OR NECK WITHOUT AND WITH CONTRAST
Attending MD: MARSHALL, JOHN Status: Finalized
Requesting MD: , Patient Loc:
ACC #: 5178341
Copy To:
Technologist:
DX:

MRI ORBITS WITH AND WITHOUT CONTRAST

HISTORY: Diplopia.

FINDINGS: Diffusion-weighted images obtained demonstrate no evidence of acute infarct.

Bilateral globes demonstrate normal shape, size and contour. The bilateral optic nerves demonstrate normal signal. No abnormal enhancement is seen of the bilateral optic nerves. Optic chiasm and optic tracts appear normal. The extraocular muscles appear normal. Bilateral lacrimal glands appear normal.

Several focal and patchy areas of chronic small vessel ischemic changes are seen involving the supratentorial white matter. The brainstem and cerebellum appears normal. The sella, suprasellar and parasellar areas appear normal. The craniovertebral junction appears normal. Calvarium appears normal. Normal signal flow voids are seen to involve the vessels of the skull base. Retention cysts are seen involving the bilateral maxillary sinuses. Bilateral mastoid air cell disease is present. Postcontrast images through the brain demonstrate no abnormal enhancement.

IMPRESSION
1. No evidence of acute infarct.
2. Normal MRI orbits with and without contrast.
3. Chronic small vessel ischemic changes involving the supratentorial brain.
4. Sinus disease.
5. Bilateral mastoid air cell disease, right greater than left.

*** THIS IS AN ELECTRONICALLY VERIFIED REPORT ***
10/31/2019 3:17 PM: ASHISH PATEL, MD
Interpreted by: ASHISH PATEL, MD

#21512-081

Bureau of Prisons
Health Services
Consultation Request

Health Services Unit
FCI Big Spring

Inmate Name: LONKEY, MILLARD J JR	**Reg #:** 21512-081	**Complex:** BIG
Date of Birth: 07/22/1953	**Sex:** M	

Report of Consultation: Ophthalmology **Subtype:** Ophthalmology Offsite Appt

Inmate Name: LONKEY, MILLARD J JR **Reg #:** 21512-081
Date of Birth: 07/22/1953 **Sex:** M
Institution: BIG SPRING FCI
1900 SIMLER AVE
BIG SPRING,Texas 79720
432-466-2300

Assessment: Pt. evaluated for vertical diplopia for 1 yr
Intermittent
VA c/c OD 20/30 OS 20/25
Ext. exam - O.S. ptosis
Partial III N. palsy OS, VI N. palsy OS.
Cornea elevate O.S. Pupil rd.
SLE - Early N.S. Cat. OS -
Retina wl - O.U.

Plan: Thyroid Fn. test T3 Free T4, TSH, FBS
MRI w/ and w/o contrast ✓
Rev 2MO.
Rx for New glasses

Signature [signature] 10-23-19
Date

Completed By:

Report may be hand-written or (preferably) typed on this form. If dictated on office or hospital letterhead to follow, please indicate essential findings or recommendations to be acted upon pending final report.

Follow-up services and primary responsibility for inmate health care remains with Bureau of Prisons staff. While discussion of diagnostic/treatment options with the inmate may be appropriate, they are subject to review by the inmate's primary care provider, the institution utilitzation review committee and/or the BOP National Formulary.

Please notify institution prior to scheduling surgery dates or follow-up appointments.

Inmate not to be informed of appointment dates.